General

Guideline Title

United Kingdom national guideline on the management of *Trichomonas vaginalis* 2014.

Bibliographic Source(s)

Clinical Effectiveness Group. United Kingdom national guideline on the management of trichomonas vaginalis. London (UK): British Association for Sexual Health and HIV (BASHH); 2014. 14 p. [86 references]

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: Clinical Effectiveness Group, British Association for Sexual Health and HIV (BASHH). United Kingdom national guideline on the management of *Trichomonas vaginalis*. London (UK): British Association for Sexual Health and HIV (BASHH); 2007. 8 p. [36 references]

Recommendations

Major Recommendations

Levels of evidence (I–IV) and grades of recommendation (A–C) are defined at the end of the "Major Recommendations" field.

Diagnosis

Testing for *Trichomonas vaginalis* (TV) should be undertaken in women complaining of vaginal discharge or vulvitis, or found to have evidence of vulvitis, and/or vaginitis on examination. Testing in men is recommended for TV contacts, and should be considered in those with persistent urethritis.

Sites Sampled

Females (III, B)

- Swab taken from the posterior fornix at the time of speculum examination
- Self-administered vaginal swabs have been used in many recent studies, and are likely to give equivalent results
- Urine has been used for evaluation with some nucleic acid amplification tests

Males (III, B)

- Urethral culture or culture of first-void urine will diagnose 60% to 80% cases, sampling both sites simultaneously will significantly increase

the diagnostic rate using microscopy or culture

Laboratory Investigations

Microscopy

Detection of motile trichomonads by light-field microscopy can be achieved by collection of vaginal discharge using a swab or loop, which is then mixed with a small drop of saline on a glass slide and a coverslip placed on top. The wet preparation should be read within 10 minutes of collection, as the trichomonads will quickly loose motility and be more difficult to identify. The slide should be scanned, firstly at low magnification (x100), and then at a higher magnification (x400) to confirm the morphology of any trichomonads and to visualise the flagella. Microscopy as a diagnostic aid for TV has the advantage that it can be performed near to the patient and in a clinic setting. The sensitivity is highest in women presenting with vaginal discharge and a visualisation of motile trichomonads in these women indicates the presence of infection. However, the sensitivity is reported to be as low as 45% to 60% in women in some studies and lower in men, and so a negative result should be interpreted with caution. The specificity with trained personnel is high.

Detection of TV by staining dead organisms with acridine orange can give a higher sensitivity than wet microscopy but is not widely used.

Point of Care Tests (IIb, B)

A number of point of care tests that have the advantages of microscopy have been described of which the OSOM Trichomonas Rapid Test (Genzyme Diagnostics, USA) has demonstrated a high sensitivity and specificity. The sensitivity and specificity has been reported to be 80% to 94% and greater than 95%, respectively, depending on the comparator. This test requires no instrumentation and provides a result within 30 mins and is a suitable alternative to culture or molecular testing. Although these tests are more sensitive than those requiring vaginal wet preparation, false positives might occur, especially in populations with a low prevalence of disease, so consideration should be given to confirming positives in that situation.

Culture (IIb, B)

Culture of TV has a higher sensitivity compared to microscopy and can detect TV in men. A commercially available culture system (InPouch TV; BioMed Diagnostics, USA), offers many advantages over previous culture media such as Diamond's medium. Once inoculated the pouches can be transferred to the laboratory for incubation and the entire pouch read microscopically each day for five days, negating the need to prepare wet preparations every day that only sample a portion of the culture medium. Culture was considered "the gold standard" but the molecular testing has proven to have a higher sensitivity.

Molecular Detection (IIb, B)

Nucleic acid amplification tests (NAATs) offer the highest sensitivity for the detection of TV. They should be the test of choice where resources allow and are becoming the current "gold standard". In-house polymerase chain reactions (PCRs) have shown increased sensitivity in comparison to both microscopy and culture, which has been found to be even greater using the commercial U.S. Food and Drug Administration (FDA) approved platform which can detect TV deoxyribonucleic acid (DNA) in vaginal or endocervical swabs and in urine samples from women and men with sensitivities of 88% to 97% and specificities of 98% to 99%, depending on the specimen and reference standard (APTIMA TV, Genprobe). In-house PCRs need validation before use on clinical specimens and are unlikely to be offered by many laboratories. However the APTIMA TV uses the same technology as testing for chlamydia and gonorrhoea, so that additional hardware will not be necessary and is becoming more widely available.

Management

General Advice

Sexual partner(s) should be treated simultaneously. Patients should be advised to avoid sexual intercourse for at least one week and until they and their partner(s) have completed treatment and follow-up.

Patients should be given a detailed explanation of their condition with particular emphasis on the long-term implications for the health of themselves and their partner(s). This should be reinforced by giving them clear and accurate written information (see www.bashh.org/guidelines for patient information leaflet).

Further Investigations

Screening for coexistent sexually transmitted infections (STIs) should be undertaken in both men and women.

Treatment

Systemic antibiotic therapy is required to effect a permanent cure due to the high frequency of infection of the urethra and paraurethral glands in females. A Cochrane review has found that almost any nitroimidazole drug given as a single dose or over a longer period results in parasitological cure in >90% of cases. Oral single dose treatment with any nitroimidazole seems to be effective in achieving short term parasitological cure, but is associated with more frequent side effects than either longer oral or intravaginal treatment. Intravaginal treatment showed parasitological cure rates around 50% which is unacceptably low. There is a spontaneous cure rate in the order of 20% to 25%.

Recommended Regimes (Ia, A)

- Metronidazole 2 g orally in a single dose
  or
- Metronidazole 400mg to 500 mg twice daily for 5 to 7 days

Alternative Regimen

Tinidazole 2 g orally in a single dose

Tinidazole has similar activity to metronidazole but is more expensive.

Pregnancy and Breastfeeding

Metronidazole is likely to cure trichomoniasis, but it is not known whether this treatment will have any effect on pregnancy outcomes. Meta-analyses have concluded that there is no evidence of teratogenicity from the use of metronidazole in women during the first trimester of pregnancy (Ia). Metronidazole can be used in all stage of pregnancy and during breast feeding. Symptomatic women should be treated at diagnosis, although some clinicians have preferred to defer treatment until the second trimester. The British National Formulary (BNF) advises against high dose regimens in pregnancy. Metronidazole enters breast milk and may affect its taste. The manufacturers recommend avoiding high doses if breastfeeding or if using a single dose of metronidazole, breastfeeding should be discontinued for 12 to 24 hours to reduce infant exposure.

Tinidazole is pregnancy category C (animal studies have demonstrated an adverse event, and no adequate, well-controlled studies in pregnant women have been conducted), and its safety in pregnant women has not been well-evaluated. The manufacturer states that the use of tinidazole in the first trimester is contraindicated.

Human Immunodeficiency Virus (HIV) Positive Individuals

There are few data available to guide management of TV infection management in HIV positive individuals. The standard treatment recommendations are based on studies conducted in HIV-negative persons. However, a recent randomized clinical trial demonstrated that a 2 g single oral dose of metronidazole was not as effective as 500 mg of metronidazole twice daily for 7 days for trichomoniasis among HIV-infected women.

Reactions to Treatment

Patients should be advised not to take alcohol for the duration of treatment and for at least 48 hours, (72 hours for tinidazole) afterwards because of the possibility of a disulfiram-like (Antabuse® effect) reaction.

Allergy

There is no effective alternative to 5 nitroimidazole compounds. Hypersensitivity reactions have been reported in patients using metronidazole and tinidazole and it is unknown whether there is cross reactivity between the two agents. There are no data to suggest that tinidazole would be safe to use in a patient with metronidazole allergy. It is important to take an accurate history to establish that a true allergy exists. Adverse reactions which may occur include anaphylaxis, skin rashes, pustular eruptions, pruritis, flushing, urticaria, and fever. In cases of true allergy, desensitization to metronidazole has been described in case reports and could be considered (see Appendix 1 in the original guideline document). Recently, one study reported data collected from clinicians who consulted the Centers for Disease Control and Prevention (CDC) on 59 patients with suspected hypersensitivity to metronidazole. All 15 patients who underwent metronidazole desensitization and were treated with metronidazole had their infections eradicated. Alternative treatment regimens were used for 17 study subjects with a cure rate of only 29.4%.

Treatment Failure

Persistent or recurrent TV is due to inadequate therapy, re-infection, or resistance. Therefore check:

- Compliance and exclude vomiting of metronidazole
- Sexual history for possibility of re-infection and ask if partner(s) have been treated

A study investigating repeat TV infections at 1 month following metronidazole 2 g stat dose found that 7% of HIV-negative women and 10% of HIV-positive women were still infected due to treatment failure suggesting a significant number of women do not respond to single dose therapy.

Development of resistance against metronidazole and other nitroimidazoles can be due to aerobic and anaerobic resistance. In the USA, it is estimated that 5% of clinical isolates of TV exhibit some degree of metronidazole resistance, predominantly low level. Resistance tests can be of clinical benefit. Clinical and microbiological cure rates were higher in women with previous treatment failure who were treated in accordance with a treatment protocol utilising the results of a resistance test. Resistance data from the UK are lacking due to the absence of a metronidazole resistance testing service, however in 2002, one group found a 3.5% prevalence of non-response to standard dose metronidazole in the absence of re-infection and non-adherence. Clinical isolates resistant to metronidazole can be resistant to tinidazole but usually with significantly lower minimal lethal concentrations to tinidazole than metronidazole. In vitro resistance may not predict clinical response to treatment which may be relative rather than absolute and may be overcome by high dose metronidazole or tinidazole therapy. Tinidazole has a longer serum half-life, good tissue penetration, a better side-effect profile and lower levels of resistance than metronidazole so should be used when infections have not responded to metronidazole even though it is more expensive.

Treatment Protocol for Non-Response to Standard TV Therapy (Having Excluded Re-Infection and Non-Adherence)

1. Repeat course of 7-day standard therapy
   Metronidazole 400 mg to 500 mg twice daily for 7 days (III) – in those who failed to respond to a first course of treatment, 40% responded to a repeat course of standard treatment.

For patients failing this second regimen:

2. Higher dose course of nitroimidazole
   Metronidazole or tinidazole 2 g daily for 5 to 7 days, or

   Metronidazole 800 mg three times daily for 7 days (III) – in those who failed to respond to a second course of treatment, 70% responded to a higher dose course of metronidazole

For those failing this third regimen, resistance testing should be performed if available as improved outcomes were reported with a treatment protocol guided by the results of a resistance test. If resistance testing is not available high dose tinidazole regimens are recommended as in one study 65% of women with clinical treatment did not have tinidazole resistant isolates and 83% of those receiving the recommended high dose treatment were cured compared with 57% of women receiving a lower than recommended dose.

3. Very high dose course of tinidazole
   Tinidazole 1 g twice or three times daily, or 2 g twice daily for 14 days +/- intravaginal tinidazole 500 mg twice daily for 14 days (III) – in those who had failed other treatments 92% and 90% responded to a very high dose course of tinidazole

If very high dose tinidazole has been unsuccessful it is difficult to recommend one specific further treatment. Treatment of such cases can be a therapeutic challenge as treatment options are limited with little evidence to support them. The largest published case series have been with intravaginal paromomycin and intravaginal furazolidone. There are anecdotal reports of treatment success with a number of other treatments. The reports are based on success in one or two women who had usually received a wide variety of prior treatments. Consequently for each successful anecdote there are a number of reports of treatment failure.

4. Other treatments with some reported success (IV or Anecdotal)
   Paromomycin* intravaginally 250 mg once or twice daily for 14 days - 56% to 58% cure rate reported

   Furazolidone* intravaginally 100 mg twice daily for 12 to 14 days - 33% cure rate reported

   Acetarsol* pessaries 500 mg nocte for 2 weeks

   6% Nonoxynol-9* pessaries nightly for 2 weeks

Availability

*The medicines suggested for use in treatment failure are unlicensed products and may not be readily available for purchase in the UK. The pharmacy purchasing department may be able to source some of these products from specialist manufacturers. At the time of writing this guideline, acetarsol 500 mg pessaries and nonoxynol-9 75 mg pessaries were available from Pharmarama International Ltd. The lead time for ordering these

products for the first time may be up to 8 weeks.

Follow-up

Tests of cure are only recommended if the patient remains symptomatic following treatment, or if symptoms recur (IV, C).

Contact Tracing and Treatment

Current partners and any partner(s) within the four weeks prior to presentation should be screened for the full range of STIs and treated for TV irrespective of the results of investigations (Ib, A). See www.bashh.org/guidelines for partner notification statement (see the "Availability of Companion Documents" field).

In a male contact of TV, found to have urethritis on screening, it is reasonable to treat initially for TV and repeat the urethral smear before treating additionally for non-gonococcal urethritis (III).

There are no data available to guide treatment of the male partners of women with nitroimidazole treatment failure. Expert opinion suggests male partners should be evaluated and treated with either metronidazole 400 to 500 mg twice daily for 7 days or tinidazole 2 g single dose. There has been one report of a male partner requiring very high dose tinidazole therapy before re-infection was prevented.

Definitions:

Levels of Evidence

Level	Type of Evidence
Ia	Evidence obtained from meta-analysis of randomised controlled trials
Ib	Evidence obtained from at least one randomised controlled trial
IIa	Evidence obtained from at least one well-designed controlled study without randomisation
IIb	Evidence obtained from at least one type of well-designed quasi-experimental study
III	Evidence obtained from well-designed, non-experimental descriptive studies, such as comparative studies, correlation studies and case control studies
IV	Evidence obtained from expert committee reports or opinions and/or clinical experience of respected authorities

Grading of Recommendations

Grade	Recommendation
A (Evidence levels Ia, Ib)	Requires at least one randomised controlled trial as part of the body of literature of overall good quality and consistency addressing the specific recommendation
B (Evidence levels IIa, IIb, III)	Requires availability of well-conducted clinical studies but no randomised clinical trials on the topic of recommendation
C (Evidence level IV)	Requires evidence from expert committee reports or opinions and/or clinical experience of respected authorities. Indicates absence of directly applicable studies of good quality

Clinical Algorithm(s)

None provided

Scope

Disease/Condition(s)

Trichomonas vaginalis (TV) infection

Guideline Category

Diagnosis

Management

Prevention

Treatment

Clinical Specialty

Infectious Diseases

Obstetrics and Gynecology

Urology

Intended Users

Advanced Practice Nurses

Nurses

Physician Assistants

Physicians

Guideline Objective(s)

To assist practitioners in managing men and women diagnosed with *Trichomonas vaginalis* (TV)

Target Population

Men and women, aged 16 years or older, presenting to health care professionals, working in departments offering specialist care in sexually transmitted infection (STI) management within the United Kingdom

Interventions and Practices Considered

Diagnosis

1. Swab taken from the posterior fornix at the time of speculum examination
2. Self-administered vaginal swab
3. Evaluation of urine as a possible sample (ONLY with some nucleic acid amplification tests) (females)
4. Urethral culture or culture of first-void urine (males)
5. Laboratory investigations, including:
    - Microscopy
    - Point of care tests
    - Culture
    - Molecular detection

Treatment/Management

1. Simultaneous treatment of sexual partner(s), and sexual abstinence advice
2. Screen for coexistent sexually transmitted infections (STIs)
3. Nitroimidazole (metronidazole or tinidazole, oral)
4. Desensitization for nitroimidazole allergy
5. Considerations of pregnancy and breastfeeding
6. Management of treatment failure:
    - Assessment for compliance, vomiting, re-infection, treatment of partner
    - Repeat standard treatment
    - Higher dose course of metronidazole or tinidazole if second treatment failure occurs
    - Resistance testing
    - Very high dose course of tinidazole with or without intravaginal tinidazole
    - Alternative treatments with anecdotal support, including paromomycin, furazolidone, 6% nonoxynol-9 pessaries, and acetarsol pessaries
7. Follow-up: tests of cure

Major Outcomes Considered

- Sensitivity and specificity of diagnostic tests
- Efficacy and cost of pharmacological interventions
- Cure rates
- Patient education
- Partner notification

Methodology

Methods Used to Collect/Select the Evidence

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

This document was produced in accordance with the guidance set out in the Clinical Effectiveness Group's document "Framework for guideline development and assessment" (see the "Availability of Companion Documents" field). The 2014 guideline updates the 2007 guideline by searching PubMed 2006 to 2012 for *Trichomonas vaginalis* or trichomoniasis and limited to "human" and "English".

The Cochrane database was searched for *Trichomonas vaginalis*. The European (International Union against Sexually Transmitted Infections [IUSTI]/World Health Organization [WHO]) guideline on the management of vaginal discharge, 2011 and the 2010 United States Centers for Disease Control and Prevention (US CDC) guidelines for the treatment of Sexually Transmitted Diseases were reviewed. A general search was performed on the National Health Service (NHS) evidence search engine as well as a Google Scholar and the British National Formulary (BNF) September 2012.

Number of Source Documents

Not stated

Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

Levels of Evidence

Level	Type of Evidence
Ia	Evidence obtained from meta-analysis of randomised controlled trials
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III	Evidence obtained from well-designed, non-experimental descriptive studies, such as comparative studies, correlation studies and case control studies
IV	Evidence obtained from expert committee reports or opinions and/or clinical experience of respected authorities

Methods Used to Analyze the Evidence

Review of Published Meta-Analyses

Systematic Review

Description of the Methods Used to Analyze the Evidence

Not stated

Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

Guideline development is undertaken by a multi-disciplinary writing committee with membership determined in a transparent manner. The chair is chosen by the Clinical Effectiveness Group (CEG). The CEG lead then discusses with the chair what suggestions they might have for members from other disciplines. The additional members of the group are then invited by the CEG. Writing committee membership includes relevant professional groups (for example genitourinary medicine physicians, nurses, health advisors, pharmacists, microbiologists and other professionals from allied specialties as appropriate) and when relevant this will involve working with the appropriate British Association for Sexual Health and HIV (BASHH) Special Interest Group (SIG) and the BASHH audit group.

Patients' views and preferences are sought and considered and the process documented. This may include patient representative involvement in the writing committee, information obtained from patient interview or surveys during the writing and/or piloting process, reviewing published work on patient experiences or involving patient associations. The chair of the writing group identifies an appropriate member such as the Health Advisor to get patient feedback on the guideline. BASHH is currently developing a public panel to assist with its work and in the future this group could be approached to assist in guideline development.

Recommendations are formulated with consideration of their health benefits, side effects and risks, with evidence presented in the guideline that these issues have been addressed. Each recommendation is linked to the supporting evidence with a list of relevant references.

Consideration is given to pragmatic and organisational issues relevant to the guideline. This is sought during and may emerge from the piloting of the guideline.

The authors consider the financial cost implications of recommendations made. Where disagreement arises within the writing committee with regard to recommendations the chair attempts to resolve these (for example by a voting system or formal consensus method). The process is documented

and reported to the CEG editor. When this is not possible the CEG will review the evidence.

Rating Scheme for the Strength of the Recommendations

Grading of Recommendations

Grade	Recommendation
A (Evidence levels Ia, Ib)	Requires at least one randomised controlled trial as part of the body of literature of overall good quality and consistency addressing the specific recommendation
B (Evidence levels IIa, IIb, III)	Requires availability of well-conducted clinical studies but no randomised clinical trials on the topic of recommendation
C (Evidence level IV)	Requires evidence from expert committee reports or opinions and/or clinical experience of respected authorities. Indicates absence of directly applicable studies of good quality

Cost Analysis

A formal cost analysis was not performed and published cost analyses were not reviewed.

Method of Guideline Validation

Clinical Validation-Pilot Testing

External Peer Review

Internal Peer Review

Description of Method of Guideline Validation

The initial draft of the guideline, including the patient information leaflet (PIL) was piloted for validation by the Clinical Effectiveness Group (CEG) and a number of British Association for Sexual Health and HIV (BASHH) pilot sites. A standardised feedback form was completed by each pilot site for the PIL. The final draft guideline was then reviewed by the CEG using the Appraisal of Guidelines for Research and Evaluation (AGREE) instrument before posting it on the BASHH website for external peer review for a two month period. Concurrently it was reviewed by the BASHH Public and Patient Panel. Comments received were collated by the CEG editor and sent to the guideline chair for review and action. The final guideline was approved by the CEG and a review date agreed before publication on the BASHH Web site.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of supporting evidence is graded and identified for selected recommendations (see the "Major Recommendations" field).

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

Appropriate diagnosis, management, and treatment of *Trichomonas vaginalis*

Potential Harms

- Adverse reactions to nitroimidazole compounds which may occur include: anaphylaxis, skin rashes, pustular eruptions, pruritis, flushing, urticaria, and fever.
- Hypersensitivity reactions have been reported in patients using metronidazole and tinidazole and it is unknown whether there is cross reactivity between the two agents.
- Oral single dose treatment with any nitroimidazole seems to be effective in achieving short term parasitological cure, but is associated with more frequent side effects than longer oral treatment.
- Patients should be advised not to take alcohol for the duration of treatment and for at least 48 hours (72 hours for tinidazole) afterwards because of the possibility of a disulfiram-like (Antabuse® effect) reaction.
- Metronidazole enters breast milk and may affect its taste. The manufacturers recommend avoiding high doses if breastfeeding or if using a single dose of metronidazole, breastfeeding should be discontinued for 12 to 24 hours to reduce infant exposure.
- The sensitivity of microscopy is reported to be as low as 45% to 60% in women in some studies and lower in men, and so a negative result should be interpreted with caution.
- Although point of care tests are more sensitive than those requiring vaginal wet preparation, false positives might occur, especially in populations with a low prevalence of disease, so consideration should be given to confirming positives in that situation.

Contraindications

Contraindications

The manufacturer states that the use of tinidazole in the first trimester is contraindicated.

Qualifying Statements

Qualifying Statements

The recommendations in this guideline may not be appropriate for use in all clinical situations. Decisions to follow these recommendations must be based on the professional judgement of the clinician and consideration of individual patient circumstances and available resources. All possible care has been undertaken to ensure the publication of the correct dosage of medication and route of administration. However, it remains the responsibility of the prescribing physician to ensure the accuracy and appropriateness of the medication they prescribe.

Implementation of the Guideline

Description of Implementation Strategy

An implementation strategy was not provided.

Implementation Tools

Audit Criteria/Indicators

Patient Resources

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report

Categories

IOM Care Need

Getting Better

Staying Healthy

IOM Domain

Effectiveness

Patient-centeredness

Identifying Information and Availability

Bibliographic Source(s)

Clinical Effectiveness Group. United Kingdom national guideline on the management of trichomonas vaginalis. London (UK): British Association for Sexual Health and HIV (BASHH); 2014. 14 p. [86 references]

Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

1999 Aug (revised 2014)

Guideline Developer(s)

British Association for Sexual Health and HIV - Medical Specialty Society

Source(s) of Funding

This guideline was commissioned, edited and endorsed by the British Association for Sexual Health and HIV (BASHH) Clinical Effectiveness Group (CEG) without external funding being sought or obtained.

Guideline Committee

Clinical Effectiveness Group (CEG)

Composition of Group That Authored the Guideline

Authors: Jackie Sherrard, Consultant Genitourinary (GU) Physician, Oxford University Hospitals NHS Trust, Oxford; Cathy Ison, Head of the Sexually Transmitted Bacteria Reference Unit (STBRU), Public Health England, Colindale, London; Judith Moody, HIV specialist pharmacist, Oxford University Hospitals NHS Trust, Oxford; Emma Wainwright, GUM Specialty Registrar, Oxford University Hospitals NHS Trust, Oxford;

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Financial Disclosures/Conflicts of Interest

All members of the guideline writing committee completed the British Association of Sexual Health and HIV (BASHH) conflict of interest declaration at the time the guideline's final draft was submitted to the Clinical Effectiveness Group (CEG). JW has received research grant funding in the form of equipment from Gen-Probe.

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: Clinical Effectiveness Group, British Association for Sexual Health and HIV (BASHH). United Kingdom national guideline on the management of *Trichomonas vaginalis*. London (UK): British Association for Sexual Health and HIV (BASHH); 2007. 8 p. [36 references]

Guideline Availability

Electronic copies: Available from the British Association for Sexual Health and HIV Web site .

Availability of Companion Documents

The following are available:

- 2012 BASHH statement on partner notification for sexually transmissible infections. London (UK): British Association for Sexual Health and HIV (BASHH); 2013 Jun. 10 p. Electronic copies: Available in Portable Document Format (PDF) from the British Association for Sexual Health and HIV (BASHH) Web site .
- Clinical Effectiveness Group. British Association for Sexual Health and HIV: framework for guideline development and assessment. London (UK): British Association for Sexual Health and HIV (BASHH); 2010. 18 p. Electronic copies: Available from the BASHH Web site .

In addition, auditable outcomes are provided in the original guideline document .

Patient Resources

The following is available:

- Common sexually transmitted infections (STIs): *Trichomonas vaginalis* (TV). Patient information. Birmingham (UK): Birmingham Sexual Health-University Hospitals Birmingham/NHS Foundation Trust. Electronic copies: Available from the British Association for Sexual Health and HIV (BASHH) Web site .

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a

licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

NGC Status

This summary was completed by ECRI on June 15, 2000. The information was verified by the guideline developer on October 13, 2000. This summary was updated by ECRI on June 24, 2002. This NGC summary was updated by ECRI Institute on December 12, 2007. The updated information was verified by the guideline developer on February 7, 2008. This NGC summary was updated by ECRI Institute on April 21, 2014. The updated information was verified by the guideline developer on May 12, 2014.

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